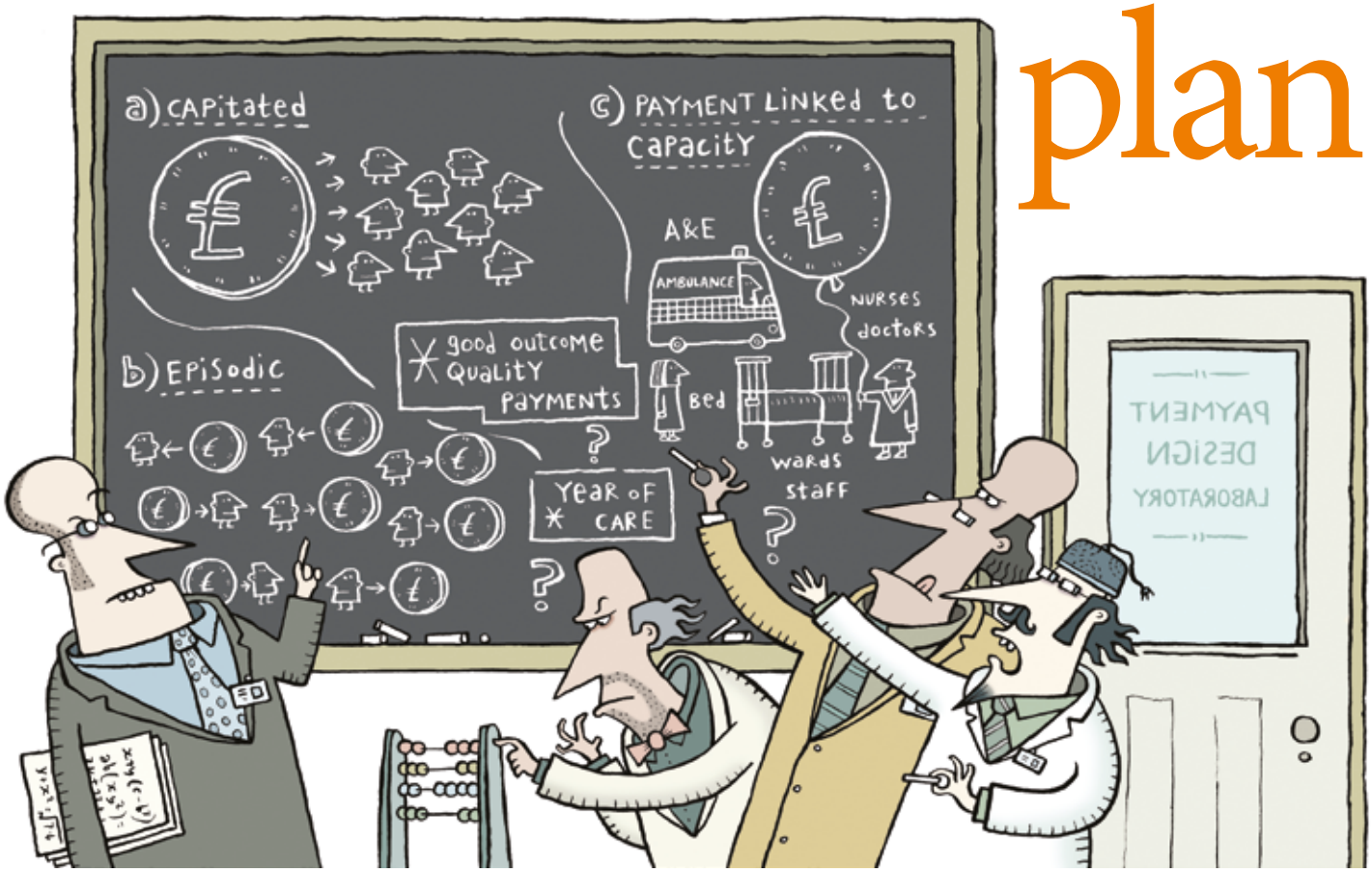
Price plan

Matching the right payment approach to different healthcare services is vital to supporting healthcare transformation and steady progress is being made according to Monitor's Toby Lambert. Steve Brown reports



SPIKE GERRELL

It has been more than three years since Monitor published an evaluation of the NHS reimbursement system and more than two years since it took charge of pricing and the payment system alongside NHS England.

On the face of it, little has changed. There have been few significant departures from the activity-based payment system the two bodies inherited. And at the end of last year and beginning of 2015, the tariff plunged into controversial new territory – as providers objected to the 2015/16 tariff requiring emergency measures to be put in place.

But despite this, new head of pricing at Monitor Toby Lambert believes significant progress has been made over the past few years and that a revised payment system remains vital to support a transformed NHS delivering services based on new ways of working.

Mr Lambert, former director of strategy at the regulator, believes payment approaches need to be matched to the type of care being delivered and the patients it is being delivered to. He rejects block contracts as too crude to support the right outcomes.

'They may be an effective way of controlling spend, but in effect they would disincentivise activity, which is very likely to show up somewhere else, for example in waiting lists,' he says.

In addition, he believes that, with 8%-9% of the country's gross domestic product spent on health, the idea that you'd want to pay for all services on the same basis 'must be wrong'.

'Different types of services and characteristics mean you'd expect different payment approaches,' he says. And while he rules out widespread use of block contracts, he adds that 'the tariff is fit for some services, but by no means the obvious approach for all services.'

Episodic interventions make sense on a tariff. 'But if you are trying to keep people healthy and stop exacerbations, you probably wouldn't do it on activity-based payment system – you'd want to look at capacity and outcomes,' he says.

Monitor's 2013 discussion paper, *How can the NHS payment system do more for patients?,* was clear. 'We expect that changing the payment system will take some time,' it said. This assessment hasn't changed.

Reform time

'We are just two years in and reforming tariff systems takes time,' says Mr Lambert. 'It originally took eight to nine years to introduce payment by results and about five years before we started a four year phasing. These things are inevitably slow.'

He suggests there needs to be a distinction between changing mandatory rules and pricing and new payment models. So expectation needs to be managed – about timescales, but also about the role of payment systems. 'Payment systems can only support new models and ways of working; they can't drive them,' he says.

This view can be seen clearly in Monitor and NHS England's approach to date. First, the payment system is not just about national prices.

But where national prices do not exist, there should be a rules-based approach to agreeing local prices or payment approaches. Second, local approaches that move away from national prices or currencies are actively encouraged – as long as local health economies inform Monitor of what they are doing. The very clear message is: don't wait for the payment system to be in place before you change patient pathways.

The simple three-stage process set out by Monitor for all payment system development is:

- Demonstrate and build (including evaluation of new approaches)
- Scale up and embed
- Normalise (which could involve mandatory prices or currencies).

Monitor clearly sees payment system reform as a partnership with local health economies testing out new approaches, which can then be evaluated for their potential to be used on a national basis.

However, it recognises that some areas don't have the capacity to develop these new approaches and, in some cases, it makes more sense to do the thinking once, rather than having multiple similar approaches being worked up in different places around the country.

So it has pursued some potential new payment approaches centrally. The three-part approach to a possible new urgent and emergency care payment system – reflecting capacity, activity and quality (see box) – is one example. But the regulator has also provided some support for health economies looking to put new payment approaches in place to support integration, whether as part of integrated care pioneers or vanguards testing the proposed new multi-specialty community provider (MCP) or primary and acute care (PAC) systems.

Its publication *Capitation: a potential new payment model to enable integrated care*, published at the end of 2014, provides a step-by-step guide to calculating a capitated payment – although some may argue that the guidance still leaves a lot of work and negotiation to be undertaken locally.

Capitation payments – given to a provider for delivering the majority or all care to a defined population (for example, frail elderly or those with multiple long-term conditions) – is not the only new approach likely to be part of Monitor and NHS England's long-term payment system. Year-of-care budgets, which are different to capitated payments in that they are single condition specific, will line up alongside capacity/volume approaches (such as for urgent care) and more traditional activity-based payments, increasingly adjusted to reflect quality and outcomes.

Arrival of HRG4+

Next year (2016/17) should see the introduction of HRG4+ – the new version of healthcare resource groups that takes a much more detailed approach to recognising comorbidities. Monitor remains keen to explore service-specific approaches to payment – similar to the relatively new pathway system for maternity. And further best practice tariffs are also likely (plus the retirement of tariffs that have already achieved their goal of raising quality).

Alongside all of this is the Monitor-led work to improve NHS costing. This is vital to price-setting nationally and locally, whether paying on the basis of capitation, episodes or capacity. But the work would be important even without a rules-based payment system.

'We can't demonstrate if the new models are worth anything if we don't know what we are getting out for the money we put in,' says Mr Lambert. And better cost data should inform local decision-making – transformative or not.

So while there may have been few major changes to mandatory tariffs since the new regime was put in place, Mr Lambert insists there has been significant progress getting the foundations in place and starting to support local experimentation.

The attraction of sophisticated payment systems for governments and policy-setters is the creation of levers to reinforce policy priorities. If you want health economies to move more care into community settings, you want to avoid any perverse incentives and encourage adoption of the new pathways. But in all cases Mr Lambert is clear, the payment

Urgent tariff change

A new urgent and emergency care tariff could be in place by 2017/18, delegates at the HFMA payment systems conference in May were told.

NHS England and Monitor ran a workshop on the proposed new approach. This will be followed up in June with the publication of a local payment example showing how the system could work.

The system could cover all types of urgent and emergency care, but is likely to focus initially on core activities such as emergency admissions, accident and emergency (A&E) attendances, ambulance activity and GP out-of-hours services.

The changes aim to address concerns

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Toby Lambert (above)

system has to produce a net gain for patients. 'The cost of setting up [and running] a more sophisticated system has to be compared against the benefits you see back from it.'

However, sending signals through prices to commissioners and providers is only part of the story. Health economies need to pick up the signals and be able to respond – and that can be difficult amid all the noise created by the current financial challenges and local and national financial support arrangements and risk sharing mechanisms.

You can reduce or increase payment to reflect quality as much as you want. But if the provider is in deficit and receiving additional support, or if its commissioner is overspent, those signals are likely to be ignored or seen as a side issue.

'You need some degree of headroom to be able to respond to incentives in the payment system,' Mr Lambert concedes. 'Expecting health economies to respond to pricing signals with all [the current financial challenges] going on is a rather heroic assumption,' he says.

But how can this 'headroom' be created? Mr Lambert is convinced that some of the new models, which can be supported by new payment approaches, will deliver savings quite quickly. Extensivist models of care – similar to the MCP models – are one example, he suggests. 'So there may need to be some upfront funding, but not a long period of double running costs,' he says. 'If you set it up right, you can see the benefits quite quickly.'

More will be needed though to enable health economies to meet current demand while transforming themselves to be sustainable for the long term. 'We need to be clear what we expect them to achieve and ensure that what we are expecting them to achieve is actually deliverable.' The 'we' refers to 'policy makers', he says.

'It is not credible to say to the system that it must hit all its activity, balance the books, hit all the quality metrics, cut administration and simultaneously transform. That is too much of an ask,' he continues. 'We need to be clearer on the things we really have to achieve,' adding that the payment system should not be used as a 'balancing lever to somehow make the system look affordable'.

This greater clarity over what is expected is also the key to not repeating the problems with the 2015/16 tariff. Mr Lambert says providers had concerns about the affordability of services under tariff and, with a lack of other opportunities to protest, felt the tariff objection process was the only way to get their voice heard. 'There was a bit of transference onto the tariff system,' he says, 'but that was entirely understandable.'

He acknowledges that the introduction of the risk share around specialised services 'late in the process' was 'unhelpful'. But he does not anticipate major changes in the tariff process or schedule and no reduction in providers' ability to object, which would 'not be dealing with the fundamental problem'.

With growing provider deficits forecast for 2015/16, it is a definitely a problem that needs addressing urgently.

over current funding approaches, which are largely related to activity despite many providers' costs remaining fixed even when activity is low.

The approach would see provider payments composed of three elements. A capacity element would reflect the always-on nature of some urgent care services. A volume payment would change depending on activity and would most likely be based on a percentage of the prices for activity currencies such as healthcare resource groups for emergency admissions and A&E attendances. Finally, a quality payment would link to performance and outcomes.

Monitor pricing development lead Jyrki Kolsi (below) told the workshop a baseline could initially be set on agreed activity (by commissioner and provider), taking account of local demand management and efficiency requirements and using existing currency prices. Different splits between the capacity, volume and quality components are envisaged for different services and potentially from health economy to health economy.

In a worked example on emergency admissions, the workshop considered a tariff with the capacity component set at 60%, quality at 5% and the volume component effectively providing a marginal rate of 35%.

One of the aims of the approach is to support changes in the urgent care pathway. 'Having a fixed element and an outcome element should be a better way of providers having certainty around investment in community services,' said Mr Kolsi. This could be enhanced by agreeing longer term contracts for urgent care contracts with prices fixed for the duration.

With significant practical issues still to be addressed, the approach is likely to be piloted in some sites and services in 2016/17.